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I. INTRODUCTION

A. Purpose

The California Department of Health Services, Tobacco Control Section (CDHS/TCS), is committed to ensuring that all populations in California benefit from the California Tobacco Control Program. It is a high priority for CDHS/TCS to: 1) expand the number of agencies serving priority populations; 2) improve the capacity of CDHS/TCS-funded projects and their subcontractors and/or consultants to address priority populations; and, 3) expand the involvement of individuals with experience in working with priority populations in CDHS/TCS workgroups and campaigns. **See Appendix A for additional information.**

Therefore, the purpose of this Request for Applications (RFA) is to fund a single training and technical assistance provider, the Capacity Building Center for Diverse Populations (Capacity Building Center). The Capacity Building Center shall provide training and technical assistance to agencies funded by CDHS/TCS as primary contractors, subcontractors and/or consultants. It is also anticipated that the Capacity Building Center will provide training and technical assistance to agencies not funded by CDHS/TCS but who are applying for funding to CDHS/TCS. Training and technical assistance services are to enhance and improve the ability of agencies in California to engage, work with, conduct, and evaluate culturally appropriate and competent evidence-based tobacco control interventions addressing the following priority populations: 1) African American (AA); 2) American Indian/Alaska Native (AI/AN); 3) Asian and Pacific Islander (API); 4) Hispanic/Latino (H/L); 5) Lesbian, Gay, Bisexual, and Transgender (LGBT); 6) Low Socio-Economic Status (Low SES); 7) Blue and Pink Collar Workers; and, 8) Rural Residents. Services must be planned, coordinated, and delivered in such a manner that recognizes the California Tobacco Control Program (CTCP) is a mature program, in existence since 1989 and that CDHS/TCS funds several other statewide training and technical assistance projects. These are as follows: California's Clean Air Project (CCAP), the California Youth Advocacy Network (CYAN), the Center for Tobacco Policy and Organizing (the Center), the Technical Assistance Legal Center (TALC), the Tobacco Education Clearinghouse of California (TECC), and the Tobacco Control Evaluation Center (the Evaluation Center). In addition, other competitive grantees provide limited assistance to specialized areas related to tobacco industry sponsorship and divestment of tobacco industry stocks by public funds, and the California Smokers' Helpline (Helpline) will begin providing cessation-related training and technical assistance through a Cessation Center in 2007.

See **Appendix W** for more information about the CTCP and its structure. Also refer to the CDHS/TCS website, www.dhs.ca.gov/tobacco, and to the TECC website, http://www.tobaccofreecatalog.org, to gather more information about the overall CTCP.

For the purpose of this RFA, applicants are expected to utilize the definitions of priority populations provided in this section or in referenced documents. The first six priority populations listed above are discussed and defined in the Communities of Excellence in Tobacco Control, Module 3: Priority Populations Speak about Tobacco Control, which is available at www.dhs.ca.gov/tobacco/html/publications.htm. For the remaining priority populations please refer to the following definitions:

- The **Blue and Pink Collar Worker** priority population includes members of the working class. Blue Collar workers perform manual labor and earn an hourly wage. Blue Collar work may be skilled or unskilled, and may involve factory work, building and construction trades, mechanical work, maintenance, etc. Pink Collar work involves jobs traditionally held by women that typically provide lower wages. Pink Collar workers include: clerical workers, maids, nursing aides, waitresses, and food service workers. Studies have demonstrated that Blue and Pink Collar workers have disproportionately high rates of smoking.

- The **Rural Resident** priority population includes individuals who reside in areas of the state that are defined as rural by the United States (U.S.) Census Bureau. Rates of tobacco use among rural residents are higher than rates for the general California population. The U.S. Census Bureau defines an area as rural if it does **not** meet the following definition for an urban area: "An urban area generally consists of a large central place and adjacent densely settled census blocks that together have a total population of at least 2,500 for urban clusters, or at least 50,000 for urbanized areas."[1] Applicants addressing rural residents need to demonstrate that the population to be reached resides in a rural area (e.g., does not meet the criteria for an urban cluster or urbanized area as defined by the U.S. Census Bureau).

Capacity Building Center Role

The role of the Capacity Building Center is to serve as a "one stop" central and comprehensive training and technical resource to enhance the capacity of CDHS/TCS-funded projects to work with priority population communities, and to address their tobacco control-related needs. Without duplicating the services and activities of other CDHS/TCS-funded training and technical assistance projects, the Capacity Building Center will, at a minimum, provide the following services:

- Professional training and development via face-to-face, webinars, interactive web-based curricula, and other methods
- Technical Assistance via telephone, topic-specific conference calls, e-mail, listserv system, and other methods
- Develop and disseminate useful tools and products (e.g., assessment tools, how-to-guides, tip sheets, case studies) focusing on working with priority populations via TECC which disseminates educational materials for use with priority populations

[1] U.S. Census Bureau, www.census.gov.

- Information and referral to appropriate local, tribal, state, national, and federal agencies, organizations, experts, and websites
- Facilitate peer communication and collaboration among CDHS/TCS-funded projects addressing priority populations to build connections and share experiences through the use of peer-to-peer support services, newsletters, networking calls, and other methods

Goals for the Capacity Building Center

CDHS/TCS goals for the Capacity Building Center are as follows:

1. Work collaboratively and in partnership with CDHS/TCS and statewide training and technical assistance providers funded by CDHS/TCS in order to improve and enhance the capacity of CDHS/TCS-funded agencies to effectively work with diverse populations on tobacco control issues.
2. Produce high quality trainings, services, and materials that are well documented, evidence-based, and relevant to California's diverse communities.
3. Increase the proportion of CDHS/TCS-funded priority population projects who believe that their mainstream counterparts such as local health departments, general competitive grantees, and other statewide technical assistance and training contractors are doing a good to excellent job engaging, including, working with, conducting, and evaluating culturally appropriate and competent tobacco control programs for priority population communities.
4. Create and increase the awareness and use of available cultural diversity trainings, services, and materials by CDHS/TCS-funded projects.
5. Be recognized by CDHS/TCS-funded projects as a credible and reliable source of information, tools, and resources for working with priority populations in California's urban, suburban, and rural communities.
6. Demonstrate flexibility and adaptation in response to changing needs among CDHS/TCS-funded projects, tobacco use data, program evaluation, and the fiscal climate.
7. Demonstrate program and fiscal accountability with an eye towards planning, delivering, and evaluating the provision of services and products in a cost-effective, efficient manner that recognizes the high turnover among CDHS/TCS-funded local project staff and the need for accessible training and technical assistance methods and products that are not solely reliant on face-to-face methods.

Applicants are not required to subcontract components of the project if agencies possess the capability to accomplish the entire Scope of Work (SOW) in-house. For those agencies who propose subcontracting, it is required that all subcontracts be identified during the proposal process. Agencies must specify in their proposals which component(s) of the SOW would be performed under a subcontract. Refer to Section IV, Application Requirements and Instructions, (3) Budget Justification, (f) subcontracts and Consultants for more information on the requirements of the application process.

Funding for this RFA is made available pursuant to Health and Safety (H&S) Code Section 104385, which requires CDHS/TCS to award grants for projects directed at the prevention of tobacco-related diseases. Preference will be given to applicants that have demonstrated effectiveness in providing technical assistance and training on a statewide level to agencies serving the identified priority populations.

B. Background on Proposition 99 Funding

In November 1988, California voters approved the passage of the Tobacco Tax and Health Protection Act of 1988, also known as Proposition (Prop) 99. This referendum increased the state cigarette tax by 25 cents per pack and added an equivalent amount to the price of other tobacco products. The new revenues were earmarked for programs to reduce smoking, provide health care services to indigents, support tobacco-related research, and fund resource programs for the environment. The money is deposited by using the following formula: 20 percent is deposited in the Health Education Account (HEA); 35 percent in the Hospital Services Account; 10 percent in the Physician Services Account; 5 percent in the Research Account; 5 percent in the Public Resources Account; and 25 percent in the Unallocated Account (Revenue and Taxation Code Section 30124).

HEA funds both community and school-based health education programs to prevent and reduce tobacco use and is jointly administered by CDHS/TCS and the California Department of Education (CDE). Currently, CDHS/TCS receives approximately three-quarters of the funding and CDE receives approximately one-quarter of the funding available in the HEA. CDHS/TCS is responsible for supporting a statewide comprehensive tobacco control program, one of the largest public health interventions of its kind ever initiated, nationally or internationally. CDHS/TCS provides funding for 61 local lead agencies (LLAs), competitively selected community-based organizations, a statewide media campaign, and an extensive evaluation of the entire CTCP. CDE administers school-based funding to grades four through eight based on an allocation method and to high schools through a competitive grant program.

The enabling legislation for Prop 99 includes Assembly Bill (AB) 75 (Chapter 1331, Statutes of 1989), AB 99 (Chapter 278, Statutes of 1991), AB 816 (Chapter 195, Statutes of 1994), AB 3487 (Chapter 199, Statutes of 1996), Senate Bill (SB) 99 (Chapter 1170, Statutes of 1991), SB 960 (Chapter 1328, Statutes of 1989), SB 493 (Chapter 194, Statutes of 1995); the annual State Budget; H&S Code Sections 104350-104480, 104500-104545; and the Revenue and Taxation Code Sections 30121-30130. These statutes and legislative language provide authority for programs administered by CDHS/TCS to:

- Conduct health education interventions and behavior change programs at the state level, in the community and in other non-school settings
- Apply the most current research and findings

- Give priority to programs that demonstrate an understanding of the role community norm change has in influencing behavioral change regarding tobacco use

C. **The California Tobacco Control Program Progress and Challenges**

CTCP has been enormously successful. Adult smoking prevalence declined from 24.9 percent in 1984 to 14.0 percent in 2005, which reflects a 43.8 percent overall decline. Tobacco consumption has declined by 57.5 percent in California from fiscal year (FY) 1989-90 to FY 2004-05, while in the rest of the U.S. it has only declined 24.0 percent. Youth smoking prevalence has also declined dramatically in California, although in the most recent year, smoking prevalence rose from 13.2 percent in 2004 to 15.4 percent in 2006, echoing a national trend. Nevertheless, California youth have a significantly lower smoking prevalence compared to the rest of the U.S., and California had the second lowest youth smoking prevalence in the nation in 2004. These declines in smoking and consumption have translated into real health gains for Californians. Accelerated reductions have been documented in California for both heart disease deaths and lung cancer incidence rates. From 1988-2002, lung and bronchus cancer rates in California declined at almost four times the rate of decline in the rest of the U.S. See **Appendix A** for additional background information on CTCP.

Despite the tremendous accomplishments of CTCP, there are still approximately 3.8 million adult and 200,000 youth smokers in California. In fact, the number of smokers in California exceeds the entire population of the state of Oregon. The burden of smoking is not equally shared across populations and communities in California. The low-income population, AA men and women, white men, Korean men, enlisted military personnel, LGBT, young adults, rural populations, and other populations experience tobacco use rates much higher than the general population.

For additional information on specific populations and communities that are impacted in unique ways by tobacco use and secondhand smoke (SHS) exposure, please refer to the following documents available at www.dhs.ca.gov/tobacco/html/publications.htm:

- *California Asian Indian Tobacco Use Survey - 2004*
- *California Active Duty Tobacco Use Survey - 2004*
- *California Chinese American Tobacco Use Survey - 2004*
- *California Korean American Tobacco Use Survey - 2004*
- *California Lesbians, Gays, Bisexuals and Transgender Tobacco Use Survey - 2004*

- *California Tobacco Control Update 2006: The Social Norm Change Approach*

- *Communities of Excellence in Tobacco Control, Module 3: Priority Populations Speak about Tobacco Control*

*Please refer to **Appendices M-V** for recent Needs Assessment Survey Results Summaries conducted by CDHS/TCS-funded projects.*

D. The California Tobacco Control Program Priorities

The aim of CTCP is to change the broad social norms around the use of tobacco by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible."[2] The social norm change model is based on the concepts that "the thoughts, values, morals, and actions of individuals are tempered by their community" and "durable social norm change occurs through shifts in the social environment of local communities, at the grassroots level."

Under this social norm change paradigm, CTCP focuses its tobacco control activities on the listed priority areas described in more detail below:

1. **Reducing the exposure to SHS**: initiatives that employ a policy and advocacy approach to restricting smoking in public and private places (emerging areas include policies associated with Indian casinos, multi-unit housing, and outdoor venues).
2. **Reducing tobacco availability**: supporting enforcement of the existing law that prohibits selling tobacco to minors, eliminating free tobacco product sampling, licensing of tobacco retailers, and establishing tobacco-free pharmacies.
3. **Countering pro-tobacco influences in the community**: working to curb tobacco product retail advertisements and marketing practices, tobacco industry sponsorship, and the depiction of tobacco products in the entertainment industry.
4. **Promote cessation services**: as a complement to the social norm change paradigm, CTCP supports operation of the Helpline, as well as provides support for community-based cessation programs.

E. History of California Priority Population Funding for Statewide Projects

From 1991 to 2004, CDHS/TCS provided funding for four Ethnic-Specific Tobacco Education Networks to serve the following four ethnic groups: 1) AA; 2) AI/AN; 3) API; and, 4) H/L. The idea to fund the Ethnic Networks evolved from the many requests of competitive grantees for training and technical assistance on how to network and share resources related to addressing these populations. Initially, the goals were to build leadership, assess and coordinate the cultural appropriateness of health education materials, provide training and technical assistance, and disseminate ethnic-specific, tobacco-related information. In the mid 1990s, the

[2] A Model for Change: The California Experience in Tobacco Control/California Department of Health Services, Tobacco Control Section. -- Sacramento, CA: CDHS/TCS, 1998.

Ethnic Networks expanded their scope to include advocacy campaigns and joint Ethnic Network activities. Advocacy campaigns focused primarily on ethnic-specific tobacco issues as they related to CDHS/TCS program priority areas. Campaigns included: *Stop the Sale of Our Image*, which countered American Indian imagery in tobacco advertising; *Regale Salud*, which developed smoke-free housing policies for the H/L population; *Not in Mama's Kitchen,* an AA campaign related to smoke-free home policies, and a campaign to create smoke-free churches and temples in the API communities.

As funding levels decreased, CDHS/TCS funded fewer community-based organizations conducting population specific interventions. CDHS/TCS decided that the focus needed to change from "networking" and working with competitive grantees targeting racial/ethnic communities, to assisting with improving the capacity of mainstream organizations such as local health departments to enhance their ability to address priority populations.

In 2004, CDHS/TCS expanded the four Ethnic Networks to seven California Priority Populations Partnership (CPPP) projects in recognition that there were additional populations besides racial/ethnic groups that needed further engagement in tobacco control efforts. The CPPPs were funded to: 1) provide technical assistance and training to the field to improve the capacity of LLAs and competitive grantees to provide services to the various populations served by CPPPs, 2) conduct advocacy campaigns in their respective communities which would result in the development of turn-key toolkits that could be used on a statewide basis, and, 3) provide representation on CDHS/TCS workgroups and the Materials Review Committee for TECC. Additionally, a few CPPPs were funded to conduct tobacco-use cessation efforts.

In May 2005, CDHS/TCS released a pilot project procurement ("Addressing Priority Populations in Tobacco Control" RFA TCS 05-102) which targeted agencies new to tobacco control or inexperienced in contracting with a state agency, but which had excellent access to racial/ethnic and cultural communities that had high rates of tobacco use. CDHS/TCS recognized that these agencies were often not competitive in its general procurements, but if provided training and technical assistance related to conducting a needs assessment, developing a plan, and learning about community norm change tobacco control strategies, they could be strong partners in California's tobacco control efforts.

As a result, CDHS/TCS issued a procurement that involved two phases: Phase I, a nine-month community assessment and planning phase, and Phase II, the implementation phase. Phase I was designed to provide smaller and inexperienced agencies the opportunity to build their fiscal and programmatic capacity within a prescribed supportive environment before transitioning to regular CDHS/TCS grant requirements. In order to receive funding in Phase II, agencies had to participate in a number of trainings, complete a needs assessment, and submit a viable SOW and

budget for the implementation phase. The procurement solicited applications addressing the following communities: AA; AI/AN; API; H/L; LGBT; and Low SES.

CDHS/TCS awarded 22 Phase I Planning grants and provided 21 regional technical assistance workshops on topics including: various tobacco control issues, priority population partnerships, evaluation, media spokesperson, materials development, automated reporting system, and CDHS/TCS grant requirements. Of the original 22 Phase I planning grants awarded, 16 were successful with their Phase II implementation grants. Of these, three projects serve API populations, three address Low SES, three targets both H/L and Low SES, two address LGBT populations, and the H/L, AA, and AI/AN populations are each addressed by one project.

Today, there is increasing recognition that other groups with high rates of smoking exist and need to be addressed. The current CPPP model does not permit sufficient flexibility to add additional groups, nor does it address the fact that priority populations do not exist in isolation of each other. The model, in which projects provide services on a statewide basis to priority populations, restricts technical assistance activities to just seven priority populations. Additionally, this model restricts the program's ability to expand or change emphasis as new priority populations emerge. Sustaining this model could lead to further fragmentation and increased complexity in coordinating and delivering technical assistance and training services. Therefore, CDHS/TCS has developed a new model to fund tobacco control work with priority populations: 1) advocacy specific interventions through RFA TCS 07-100, which was released in February 2007; and, 2) this specific RFA seeks a technical assistance and training provider.

F. **Communities of Excellence (CX) Asset Priorities for Funding**

Since 2002, CDHS/TCS has focused tobacco control needs assessment, planning, implementation, and evaluation activities around a series of community indicators and assets called CX in Tobacco Control. Community indicators represent environmental or community-level measures. They reflect intermediate programmatic goal areas around which to focus community-level tobacco control activities. Community assets represent factors that promote and sustain tobacco control efforts in the community by facilitating tobacco control work. Assets include such topics as the level of funding available for tobacco control work and the extent of community activism among youth and adults to promote tobacco control policies.

There are over 90 CX Indicators and Assets. The majority of CX Indicators and Assets are applicable to CDHS/TCS-funded projects that work directly with communities to create and implement tobacco control interventions. However, the focus of this procurement is on the provision of training and technical assistance services statewide to enhance the capacity of CDHS/TCS-funded projects and others to conduct culturally competent tobacco control interventions within California's diverse communities. Therefore, applicants may <u>only</u> design objectives

and interventions that focus on the assets listed below. It is not expected or desired that applicants address each of the assets listed below in its application. **CDHS/TCS will give funding preference to projects that address assets that are listed as highly relevant**, but applicants are encouraged to consider the assets designated as "relevant" and address them if appropriate and it considers there are sufficient resources to do so. When considering these assets, it is important that the applicant keep in mind that the goal of this procurement is not to provide direct services to communities, but to provide services to agencies that work directly with communities. For example, in terms of Asset 3.1, the applicant might design training and technical assistance that would assist CDHS/TCS-funded projects to increase the number and diversity of people participating on tobacco control coalitions and advisory committees versus being responsible for doing this directly themselves.

1. **Community Assets**

   a. **Highly Relevant**

   3.1 Number and diversity (e.g., ethnic, cultural, sexual orientation) of partners participating in coalition or advisory committee is relative to their proportion in the community

   3.6 Extent to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to the demographics of the community

   3.7 Extent to which a tobacco control program implements organizational policies and practices that promote and institutionalize the provision of culturally competent and linguistically appropriate services for diverse populations, including organizational values that articulate commitment to cultural competency, participatory collaborative planning, provision of community capacity building, translation policies, staff diversity, and formative research/surveillance within diverse communities

   b. **Relevant**

   3.3 Extent that the coalition or advisory committee by-laws and member agency mission statements promote cultural diversity and competency

2. **Social Capital Assets**

   a. **Highly Relevant**

   2.1 Number of tobacco control advocacy trainings that are provided to youth and adults

b. **Relevant**

2.3 Amount of support by local key opinion leaders for tobacco-related community norm change strategies

2.4 Amount of community activism among youth to support tobacco control efforts

2.5 Amount of community activism among adults to support tobacco control efforts

2.6 Number and type of non-traditional partners participating in coalitions or advisory committees facilitates tobacco control efforts